22 Layton: *Tuberculosis of Larynx;* Howarth: *Laryngeal Lesion*

Tuberculosis of Larynx.

By T. B. LAYTON, D.S.O., M.S.

A. D. B., MALE, aged 48.

November 18, 1925.—Seven months' hoarseness, whole larynx injected. Both V.B.'s swollen and irregular. Interarytænoid space filled up with irregular mass. Vocal cords red, not swollen or ulcerated. Appeared to have pain in swallowing. Advised to go into sanatorium; given advice pending admission. Met casually on December 2, 1925, when he looked so much worse that he was told to go to bed at once and stay there till he got into the sanatorium.

December 18, 1925.—Admitted King Edward VII Sanatorium. Stage II. Right lung + + ; left lung + infiltration.

Larynx (Sir StClair Thomson): Epiglottis congested and infiltrated with ulcer on left border and all laryngeal surface. Ulcerating deposit of left aryepiglottic and of both ventricular bands, largely concealing vocal cords. No dysphagia. Interarytænoid clear. Silence ordered.

February 27, 1926. Clean and subsiding. Posterior two-thirds of vocal cords showed clear.

March 20, 1926.—Vocal cords clear, but anterior quarter concealed by ulcerating deposit on both V.B.'s. Right arytænoid seemed clear, and also left, except that it did not leave and expose the left sinus pyriformis. Interarytænoid clear.

April 15, 1926.—Both vocal cords seen to be intact, though catarrhal and faintly pink. Interarytænoid sound. Both arytænoids enlarged, but mobile and clear. Each sinus pyriformis clear. Much ulceration of epiglottis and both V.B.'s. Galvanocautery (1st) five points epiglottis, two in R.V.B.

May 15, 1926.—Healing, good scar in R.V.B. G.C. (2nd) five points epiglottis, two in L.V.B.

June 19, 1926.—Vocal cords clear. A little thickening over anterior part of L.V.B. Epiglottis very irregular, but healing.

Discharged June 28, 1926. Lung disease improved, quiescent—sputum negative in twenty-four examinations; weight increased from 9 st. 12 lb. to 10 st. 11 lb.

Seen by exhibitor September 17, 1926. Irregularity upper margin epiglottis. General redness including cords, swelling front end R.V.B., which prevented view of front end of vocal cord; no granulations. Advised to continue whispering for a time.

October 5, 1926.—(Sir StClair Thomson): Larynx quite healed, wasted and irregular epiglottis, stump healed, scars on both V.B.'s. Rest normal. Given permission to phonate. The man's courage and implicit obedience were large factors in his recovery.

Laryngeal Lesion associated with Apparent Miliary Tuberculosis of the Lung.

By WALTER HOWARTH, F.R.C.S.

G. B., MALE, aged 21.

Hoarseness for three months. Examination showed a granulomatous patch at the anterior end of the right vocal cord. There was no limitation of movement.

Portion removed for microscopy showed typical tubercle. There were no physical signs of disease in the lung, but the skiagram shows that both lungs are a mass of miliary tubercle. In spite of the absence of symptoms, these cases are invariably and often rapidly fatal.

Discussion.—Mr. F. T. G. HOBDAY said he had seen a cow with a tuberculoma just below the larynx. The animal was killed under the Tuberculosis Order, and was found to have been suffering from the disease in an advanced and generalized state.

Sir STCLAIR THOMSON asked whether Mr. Howarth's case was rightly defined as "miliary" tuberculosis of the larynx. It seemed to be a most chronic and quiescent condition possible, and there was no invasion of the arytenoid region, nor of the epiglottis. Mr. Howarth had informed him (the speaker) that X-ray specialists were now able to tell from the skiagram when a patient had miliary tubercle of the lung. This patient in Mr. Howarth's case had a quiet pulse, he ate well and maintained his weight, and he did not exhibit a raised temperature. It would be a great advantage if the expert radiologists could say definitely that such a man would be dead in a few months. Mr. Layton's case was quite different; it was chronic, indolent and almost lupoid from the beginning. A good prognosis had been given, yet the thorough treatment occupied seven months, and if the patient had not been in a sanatorium, he would probably have gone downhill. It was doubtful whether there had ever been tubercle bacilli in his sputum; they were not found in it while he was in the sanatorium. When he had come under his (the speaker's) observation there was no disease in the interarytænoid or arytænoid regions, but it was extensive in the epiglottis and anterior commissure. When tubercle began in its favourite place, the arytænoid region, and then spread to the epiglottis, the outlook was very serious; but when it began in the epiglottis and the arytænoid was free, the case was, *cæteris paribus*, a favourable one.

Dr. JOBSON HORNE said that when the epiglottis was the only part attacked it was as well to exclude other possible factors from a diagnosis of laryngeal tuberculosis. Miliary tuberculosis—in the commonly accepted pathological meaning of the term—did not occur in the larynx. Diffuse, superficial, minute, discrete, multiple ulcers occurring in the pharynx or larynx in the course of tuberculosis did not constitute miliary tuberculosis.

Tuberculosis of the larynx in animals was very rare, if not unknown; the reason being that the animal either was killed or died before the disease in the lungs had had time to infect the larynx. Now that the specimen of the larynx from a cow had been laid open it was clear that the tuberculoma was below the larynx and in the trachea.

Sir WILLIAM MILLIGAN said it was difficult to explain away the evidence of the microscope, and yet on the other hand it was difficult to decide that this patient had miliary tuberculosis. He (the speaker) had never seen miliary tuberculosis of the larynx, but he had seen more than one case of miliary tuberculosis of the pharynx. Professor Dreschfeld used to teach that the nearer tuberculous disease was to the surface of the body the more rapidly fatal it was. Mr. Howarth's patient, though he presented evidences of tuberculosis in his larynx, was in such relatively good general condition that doubts arose as to the existence of miliary tuberculosis.

Mr. W. J. IBBOTSON said he had had a similar case, one in which the patient had been in a sanatorium and a very good result had been obtained from the intra-laryngeal use of radium combined with ordinary sanatorium treatment. He suggested that radium should be more widely used in the treatment of this disease.

Mr. HOBDAY said he agreed with Dr. Jobson Horne that it was not common to find tuberculosis in the actual tissue of the larynx of animals, but it was often met with in the glands in the region of the larynx of the cow. It was rare in this region in the horse, the dog and the sheep.

Mr. G. W. DAWSON asked how miliary tubercle could be diagnosed by means of the microscope.

Mr. HOWARTH (in reply) said that the case presented some unusual features. The lesion was originally on the anterior end of the right cord. There were no physical signs of disease in the chest, and a piece removed for examination was reported tuberculous. The radiologist said that both lungs were riddled with miliary tubercle and several physicians and radiologists agreed with this diagnosis. This case had followed on two other recent cases, one of which had begun very similarly and had presented almost the same X-ray picture (film exhibited). This other patient had been apparently perfectly well and without abnormal temperature but, later, extensive disease had developed and the patient had died within six months. He (Mr. Howarth) did not profess to be an expert either in pathology or radiology, but many people were apparently certain that this was a miliary condition and that the patient would not live long. Time would show. He would report on the case later.